

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be reimbursement for dates of service 08/21/00 through 10/23/01.
- b. The request was received on 02/06/02.

### **II. EXHIBITS**

1. Requestor, Exhibit 1:
  - a. TWCC 60 and letter requesting medical dispute resolution
  - b. Copies of Receipts for Proof of Payments for disputed dates of service
  - c. Requests to the carrier for reconsideration
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
  - a. TWCC 60
  - b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/28/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/28/02. The initial response from the insurance carrier was received in the Division on 06/28/02. Based on 133.307 (i) the insurance carrier's response is timely. There was no response to the additional documentation.
4. Additional Information submitted by Requestor is reflected as Exhibit #III of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor: Letter dated 06/19/02  
"The TWCC-60 form summarizes the description, dates and costs of the disputed services, (Carrier)'s response, and my response to their comments.... The requested reimbursement for the costs and services for doctor's visits, prescriptions, and physical therapy are for the amount of my personal co-pay through my company's group insurance."
2. Respondent: No Position Statement

#### IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 03/09/01, 05/18/01, 06/13/01, 08/30/01, and 10/23/01. Dates of service 08/21/00, 09/22/00, 09/26/00-10/18/00, 10/20/00, 10/27/00, 11/15/00, 12/01/00, 12/08/00, and 02/01/01 will be not be addressed because they are past the one year after the dispute was filed per Rule 133.307 (d) (1) and are not within the jurisdiction of the Medical Review Division.
2. There are no EOBs, but Requestor has proof of delivery. Therefore, the dispute will be addressed as a fee reimbursement dispute submitted by the injured worker. The total amount in dispute and paid by the injured worker is \$220.00.
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
03/09/01	99212 20550 J0702	Total of \$150.00	\$0.00	None	\$32.00 \$40.00 DOP	MFG: E/M Ground Rules; (VI) (B); Rule 133.307 (f); CPT Descriptor	In review of the dispute packet, the injured worker submitted copies of the office visit and service rendered receipts showing proof of self-pay payment. The injured worker also submitted a copy of the medical documentation. However, per Rule 133.307, an injured worker is only entitled to receive what the employee paid the provider but not to exceed the maximum allowable reimbursement. The injured worker paid a total of \$150.00 for the services billed for this office visit, but the maximum allowable reimbursement will be reimbursed for 99212 and 20550. Reimbursement is recommended in the amount of <b>\$150.00</b> . (99212 = \$32.00 MAR; 20550 = \$40.00 MAR; J0702 is a DOP)
05/18/01	Office visit	\$10.00	\$0.00	None	Co-pay (Private Insurance Carrier)	MFG: E/M Ground Rules; (VI) (B); Rule 133.307 (f);	In review of the dispute packet, the injured worker submitted a copy of the office visit receipt showing proof of cash payment. Therefore, reimbursement is recommended in the amount of <b>\$10.00</b> .
06/13/01	J8499	\$25.00	\$0.00	None	Co-pay (Private Insurance Carrier)	Rule 133.307 (f)	In review of the dispute packet, the injured worker submitted a copy of the prescription receipt showing proof of credit card payment. Therefore, reimbursement is recommended in the amount of <b>\$25.00</b> .
08/30/01	J8499	\$25.00	\$0.00	None	Co-pay (Private Insurance Carrier)	Rule 133.307 (f)	In review of the dispute packet, the injured worker submitted a copy of the prescription receipt showing proof of payment. Therefore, reimbursement is recommended in the amount of <b>\$25.00</b> .

MDR: M4-02-3049-01

10/23/01	Office visit	\$10.00	\$0.00	None	Co-pay (Private Insurance Carrier)	MFG: E/M Ground Rules; (VI) (B); Rule 133.307 (f)	In review of the dispute packet, the injured worker submitted a copy of the office visit receipt showing proof of cash payment. Therefore, reimbursement is recommended in the amount of <b>\$10.00.</b>
<b>Totals</b>		\$220.00	\$0.00				The Requestor <b>is</b> entitled to reimbursement in the amount of <b>\$220.00.</b>

### V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$220.00 to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 13<sup>th</sup> day of December 2002.

Donna M. Myers  
Medical Dispute Resolution Officer  
Medical Review Division

DMM/dmm